



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: MONARCH PAIN CARE CENTER 5151 KATY FREEWAY, STE. 305 HOUSTON, TX 77007	MFDR Tracking #:	M4-08-6527-01
	DWC Claim #:	
	Injured Employee:	
	Date of Injury:	
Respondent Name and Box #: HOUSTON ISD REP. BOX # 21	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Date of service 12/03/07 -12/06/07 was partially denied and a request for reconsideration was faxed to the Carrier's dedicated fax line on January 24, 2008...After no response was received, our office faxed this request again & sent the same via certified mail on April 23, 2008. Despite this, no response was received. A final attempt was made on June 2, 2008, certified letter to the Adjuster was mailed after telephonic contact made to attempt resolution. A phone call was placed again today July 2, 2008 to Adjuster Brenda Carr who stated to call the Bill Review department. A call was placed to Bill Review 888-382-0039. I was told nothing was in the system."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$240.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...it is the Respondent's position that the Requests for Reconsideration have not been received. Respondent is currently investigating and attempting to locate the Request for Reconsideration based on the information provided in this request...Respondent has paid all dates of service at issue in accordance with the Medical Fee Guidelines."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
12/3/07 12/6/07	97110-GP	1-4	\$67.88
12/3/07 12/6/07	97140	1-3, 5	\$63.78
12/3/07 12/6/07	97018	1-3, 6	\$0.00
Total:			\$131.66

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

On 1/6/09, the Requestor withdrew from their request for medical fee dispute resolution dates of service 1/31/08, 2/29/08, 3/10/08 and 4/4/08. These dates of service will not be considered further in this decision.

1. These services were denied by the Respondent with reason code "150-Payment adjusted because the payer deems the information submitted does not support this level of service; and F269-Procedure not valid for the date of service."
2. The Respondent raised the issue in their response that the case should be dismissed because the Requestor had not requested reconsideration of their bills prior to seeking medical dispute resolution. The Requestor submitted facsimile reports and certified mail delivery receipts to support that the bills were submitted to the insurance carrier for reconsideration prior to seeking medical dispute resolution. The insurance carrier noted in their response that they would attempt to locate the request for reconsideration EOB based upon the information they received in this dispute. At the time of this review, the request for reconsideration EOBs were not submitted by the insurance carrier. This review will be based upon the submitted EOBs contained in the dispute packet.
3. On the disputed dates the Requestor billed CPT code 97110-GP defined as, "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility." The Requestor submitted physical therapy documentation of procedure reports to support billed service; therefore, reimbursement is recommended.
4. Per review of Box 32 on CMS-1500, zip code 77007 is located in Harris County. The maximum reimbursement amount, (MAR), under Rule 134.202(b), is determined by locality. The MAR for CPT code 97110 in Harris County is \$33.94. This amount times two dates equals \$67.88.
5. The Requestor also billed CPT code 97140 on the disputed dates. CPT code 97140 is defined as "Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes." Based upon the submitted physical therapy report, the Requestor supported billed service; therefore, reimbursement is recommended. The MAR for 97140 in Harris County is \$31.89. This amount times both dates equals \$63.78.
6. In addition, the Requestor billed CPT code 97018 defined as, "Application of a modality to 1 or more areas; paraffin bath." Per Rule 134.202, CPT code 97018 is a component of 97140; therefore, no reimbursement is recommended for this service.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$131.66 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER / DECISION:

Authorized Signature

Elizabeth Pickle, RHIA

Medical Fee Dispute Resolution

1-15-09

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.